STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155131	B. WIN			08/24/2	011
NAME OF P	NAME OF PROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE	•	
MIINISTE	R MED-INN				ALUMET AVENUE		
					ER, IN46321		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION DATE
F0000	KEGGE/HOKT OK	LEGE IDENTIF TING INFORMATION		mo	<u> </u>		DATE
1.0000							
	This visit was fo	or the Investigation of	F ₀	000			
		094249. This visit					
	resulted in a part						
	survey-Immedia	•					
	Complaint IN00	094249- Substantiated,					
	*	ficiencies related to the					
		ited at F 242, F 250, and					
	F 323.	110a at 1 2 12, 1 25 0, and					
	1 323.						
	Survey dates: A	ugust 22, 23, 2011					
	Extended date, A	_					
	Extended date, 1	1ugust 24, 2011					
	Facility number:	000056					
	Provider number						
	AIM number: 1						
	Alivi liullibei. 1	00289430					
	Survey team:						
	Janelyn Kulik, R	N					
	Janeryn Kunk, N	XIN.					
	Census bed type						
	SNF: 15	•					
	SNF/NF: 177						
	Total: 192						
	Camana						
	Census payor ty	pe.					
	Medicare: 30						
	Medicaid: 125						
	Other: 37						
	Total: 192						
	Sample: 6						
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7G4011

Facility ID:

000056

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155131	B. WING		08/24/2011
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIER			ALUMET AVENUE	
MUNSTE	ER MED-INN			ΓER, IN46321	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	Supplemental sar	mple: 3			
	findings cited in 16.2.	es also reflect State accordance with 410 IAC ompleted on August 26, ilkner, RN			
F0242 SS=D	schedules, and he or her interests, as care; interact with both inside and out choices about asp facility that are sig Based on record facility failed to given the opporture lated to restrict main dining roomelopement from 1 of 6 residents reference (Resident #C). Findings include The record for Roon 8/22/11 at 11: diagnoses include	d: esident #C was reviewed 05 a.m. The resident's ed, but were not limited ementia, and senile	F0242	F-242 Submission of this response and Plan of Correctis not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of deficiency against the facility Administrator, or any employ who draft or may be discussed this response and Plan of Correction. In direct response the five questions listed on putwo of Kim Rhoades, Directo Long Term Care, letter to this facility dated August 26, 201 facility offers the following: 1 What corrective action(s) will accomplished for those reside found to have been affected	of of any of, the ees ed in e to age or of s 1, the libe lents

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED	
		155131	B. WIN			08/24/2	011	
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER					ALUMET AVENUE			
MUNISTE	MUNSTER MED-INN				TER, IN46321			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΤE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					the deficient practice? Effec			
	Review of nursing	ng notes of 7/24/11,			August 18, 2011, Resident C			
	reportable incide	ent report of 7/24/11, and			resumed Main Dining Room service. The facility is unable	o to		
		te of 7/25/11, indicated			retrospectively offer any furth			
		s found outside the facility			corrective action as it relates			
		·			Resident C's participation in			
		erty on 7/24/11. The			Dining Room service. 2. How			
		erved at a shopping			other residents having the			
	1	o the facility by another			potential to be affected by the			
		acility was notified. The			same deficient practice will b			
	resident was retu	irned without incident or			identified and what corrective	=		
	injury by facility	staff.			action(s) will be taken? The facility is confident, with the			
					implementation of our Chain	of		
	A nursing note	dated 7/25/11 at 9:00			Supervision policy and proce			
	· ·	the wanderguard remains			that residents having the nee			
		•	Wanderguard protection and who have the desire to attend the					
		Res (resident) states she						
	1	ollar store next time its			facility Main Dining Room wil			
	l ` ′	(Resident) informed she			have the necessary supervis	ion		
	is not to leave fa	cility without staff or			for meal service in the Main Dining Room. 3. What			
	family."				measures will be put into pla	ce or		
	A nursing note, of	dated 7/25/11 at 12:15			what systemic changes will be			
	p.m., indicated the	he resident was given her			made to ensure that the defic			
	_	NA. The resident was in			practice does not recur? The	:		
	1	nd set up to eat prior to			facility has implemented the			
		e room. At 12:45 p.m.,			Chain of Supervision policy a	and		
	_	• .			procedure which will allow			
		at the nurse's station in			residents with the need for Wanderguard protection to h	31/6		
		tating she did not have			the necessary supervision, if			
		er lunch was in the			desire for meal service in the			
	bathroom. The CNA indicated the resident was set by her bed and window and the resident moved the tray. The resident was ordered another lunch tray.				Main Dining Room. 4. How t			
					corrective action(s) will be			
					monitored to ensure the defic			
					practice will not recur, i.e., w			
					quality assurance program w	'III be		
	A social service note, dated 7/25/11,				put into place? The facility is committed to meeting on a			
					weekly basis for a minimum	of 12		
	indicated resider	nt was noted outside the			weekly basis for a minimul	UI 12		

Facility ID:

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155131	B. WIN	G		08/24/2011
NAME OF I	PROVIDER OR SUPPLIER		-	STREET A	DDRESS, CITY, STATE, ZIP CODE	
		•		1	ALUMET AVENUE	
MUNSTE	ER MED-INN			MUNST	ER, IN46321	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	DATE
	facility and off p				weeks and monthly thereafted deemed appropriate) to review	
		sing went to get the			and discuss all resident iden	
		rned her to the facility			as having a risk for elopemen	
		The resident indicated she			and warrant the use of	
	wanted to go sho	opping and later indicated			Wanderguard protection. Du	ıring
	she wanted to go	for a walk and was tired			these meeting the multi-disciplinary team will re	viow
	of being inside.	A new order was			the current dining arrangeme	
	received for a wa	anderguard. The resident			for each resident requiring	
		e wanderguard to wrist			Wanderguard protection to	
	and a	-			ensure that there has been r	
	wanderguard to	wheelchair was applied.			change in dining service. Sh	ould
	1 -	ussed situation and safety			a change be noted, it will be necessary to provide	
		e resident and she stated			documentation for the reason	n for
		hen she wants to. In			the change. Regardless of the	
	morning meeting				reason, Social Service will	
		niting resident's activity			provide an initial well-check	/isit
		acility until resident safety			(additional visits may be necessary and will be	
		essed. Social Service			documented as such in the S	Social
					Service section of the medical	
		ily meeting and family			record) with the resident to	
		off at this time. The			ensure that there are no	14
	, ,	reement with facility			psycho-social impacts as a roof the change and will report	
		resident safe with			concerns to The Director of	arry
	1	d limiting activities.			Social Service or	
	1 *	I they visited yesterday			Administration. 5. By what	
		oncerns with the resident.			will the systemic changes be	
	1	ated they will attempt to			completed? August 25, 201	
	take the resident	out on pass with family				
	monthly as weat	her permits. Social				
	service met with	resident and discussed				
	concerns. The re	esident had some				
	confusion and no	oted difficulty with word				
		Service will continue to				
	1	with supportive visits.				
	•	11				
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID: 7	'G4011	Facility I	D: 000056 If continuation sl	heet Page 4 of 43

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155131		A. BUIL		STRUCTION 00		X3) DATE S COMPL 08/24/2	ETED		
	PROVIDER OR SUPPLIER		B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVENUE MUNSTER, IN46321					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	=	(X5) COMPLETION DATE	
	A nursing note, of a.m., indicated, the wheelchair in her responsive, skin was informed to meals. The residunderstanding, was up in her whow to the main breakfast. She'd as I please and don't know what exactly what I'm want to leave and staying upstairs explained to the able to go downs down and stated, alright." A social service indicated the resiperiods of confustificulty with whe frustrated in comorder was received to treat moderate Social Service was supportive visits observe for chammood/behavior. A nursing note, of	dated 7/26/11 at 6:30 the resident was in her or room, alert, verbally was warm and dry. She stay on the unit for dent verbalized At 7:30 a.m., the resident neelchair attempting to go in dining room for stated to writer, "I can do to you really think that I it'm doing, I know doing. I'll leave when I d (Roommate's name) is [sic] with me." It was resident why she was not stairs. Resident calmed produced to whatever and said the stairs and resident having for finding and becomes wersation at times. A new ded to start Namenda (used to severe dementia).							
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	7G4011	Facility ID	000056	If continuation she	eet Pa	ge 5 of 43	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		A (X	2) MULTIPLE CO	NSTRUCTION		(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A	BUILDING	00		COMPL	ETED
		155131		WING			08/24/2	011
			<u>F`</u>		DDRESS, CITY, STA	ATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R		l l	ALUMET AVENU			
MUNSTE	R MED-INN			MUNST	ER, IN46321			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S P	PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FU	JLL	PREFIX	(EACH CORRECTIV CROSS-REFERENCI	VE ACTION SHOULD BE ED TO THE APPROPRIAT	E	COMPLETION
TAG	<u>'</u>			TAG	DEF	FICIENCY)		DATE
	nurse's station wanting to leave the facility							
	to go to the store	e. The resident was						
	redirected by sta	aff and Administrator wa	ıs					
	made aware.							
	A nursing note,	dated 8/7/11 at 4:30 p.m	l.,					
	indicated the res	ident indicated "she was	3					
	going to leave (s	sic) facility when she we	ent					
		writer spoke with res						
	_	formed her that she cou	ld					
	` /	cility without family or						
		lent) got angry and went						
	back to her roon							
	ouck to her room	1.						
	A Psychiatry no	te, dated 8/11/11,						
		atient) seated in room.						
		her the incident when sh						
			I .					
		to Target. She said she						
		couldn't go stating 'I use						
		nd the Dollar Store with	1					
	_	e said '5 minutes more						
		have never known.' Sh						
		m I would not do it agai	I .					
		childish about it. It mak	es					
		omething else.' I						
	-	ust now be restricted as	a					
		n action. She was not						
	accepting of this	s. She did laugh about it	.					
	when I joked ab	out it in order to lighten						
	up the moment. She brought up her							
	mother as if she	were alive. Her memor	y					
	was impaired. She now has a							
	wanderguard on her wheelchair. She							
reportedly cut the one off her arm."								
FORM CMS-2	567(02-99) Previous Versi		t ID: 7G4(O11 Facility I	D: 000056	If continuation sh	neet Pa	ge 6 of 43

PRINTED: 08/31/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155131	B. WIN			08/24/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
MUNICEE	D MED ININ				ALUMET AVENUE		
	ER MED-INN			MONSI	ER, IN46321		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DETCIENCT)		DATE
		1 . 10/15/11 7 . 45					
		lated 8/15/11 at 7:45					
	l '	ne resident was upset this					
	· -	k her breakfast tray and					
	1 ^	r in the middle of the					
	I -	a.m., the nurse spoke to					
		had her pick up the tray					
		y. The resident picked					
	the tray up and h	anded it to the nurse.					
	A social sometics	anta datad 0/16/11					
		note, dated 8/16/11,					
		service was informed by					
		was upset and requesting					
	_	removed. Resident had					
		eals at times. The					
	• •	cement was discussed					
		amily. The family was					
	informed of risks	•					
	_	explained facility desire					
		ent's independence and					
		cerns of the resident					
	I -	nd the concern of the					
		ring a negative affect on					
		discussed. The resident					
		l not leave the facility					
	again unassisted	and stated to social					
	service today she	wishes she would not					
	have left. The fa	mily feels the resident					
	will not attempt t	to leave the facility again					
	and was remorse	ful about the situation.					
	Family would lik	te the wanderguard					
	removed.						
	A nursing note, d	lated 8/18/11 at 2:40					

000056

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155131	A. BUI		00	08/24/20	
		100101	B. WIN		PPPPG GWY GWY GW	00/24/20	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ALUMET AVENUE		
MUNSTE	ER MED-INN			1	ER, IN46321		
		TATEMENT OF DEFICIENCIES	-			ı	(27.5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	n m indicated M	MDT (Multidisciplinary					
	Team) discussion	` .					
	· '	ne resident and family					
	1	rguard be removed. The					
	_	She will not leave the					
	· ·	ed, states she would like					
	· ·	oom for meals and wants					
		es. MDT feels that					
		uld be removed at this					
	ı	ducation done at this					
	time.	***************************************					
	A social service i	note, dated 8/18/11,					
		nd Psychiatrist discussed					
		ce the removal of the					
	wanderguard. Re	esident and family want					
	ı	removed. After further					
	1	feels that wanderguard					
	· ·	ed at this time. The					
		cated on safety of not					
		ing unattended. The					
	resident agrees a	_					
	Interview with th	e Administrator on					
	8/22/11 at 12:15	p.m., indicated the					
	ground floor doo	rs do not have a					
	wanderguard alai	rm. The resident was not					
	kept from the ma	in dining room due to the					
		vas due to the staff					
	monitoring the re	esident's behavior and her					
	indicating she wa	as still going to leave. It					
	was then indicate	ed with her stating she					
		ve and the doors not					
	being activated b	y the wanderguard					

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Facility ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155131		(X2) M A. BUI B. WIN	LDING	nstruction 00	(X3) DATE S COMPL 08/24/2	ETED	
	PROVIDER OR SUPPLIER	!	<u> </u>	7935 C	ALUMET AVENUE ER, IN46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODE TAG			(X5) COMPLETION DATE
	the resident to ke monitor her beha allowed to come supervised, but s meals on the uni Interview with the Unit Manager, the	the was receiving her t. ne current Second Floor ne new Second Floor Unit					
	indicated the res behaviors and no wanderguards ar unit. It was thou interest of the re- resident indepen- should be remove that the resident and did not like s	nd Assistant n 8/22/11 at 3:45 p.m.,					
	the time. This Federal tag IN00094249. 3.1-3(u)(3)	relates to complaint					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155131 08/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **7935 CALUMET AVENUE** MUNSTER MED-INN MUNSTER, IN46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must provide medically-related F0250 social services to attain or maintain the SS=E highest practicable physical, mental, and psychosocial well-being of each resident. F-250 Submission of this F0250 08/25/2011 Based on record review and interview, the response and Plan of Correction facility failed to ensure social services is not legal admission that a were provided to maintain the highest deficiency exists, or that a practicable physical, mental, and Statement of Deficiency was psychosocial well-being of each resident correctly cited. Submission of this response is not to be for 3 of 4 residents who were at risk for construed as an admission of any elopement in a sample of 6 (Residents #C, deficiency against the facility, the #D, and #G) and 1 of 3 residents who Administrator, or any employees who draft or may be discussed in were at risk for elopement in a this response and Plan of supplemental sample of 3 (Resident #J) Correction. In direct response to related to not completing annual the five questions listed on page elopement assessments per facility policy. two of Kim Rhoades, Director of Long Term Care, letter to this The facility also failed to provide social facility dated August 26, 2011, the service interventions for 1 of 6 sampled facility offers the following: 1. residents (Resident #C) after the resident What corrective action(s) will be was restricted to the unit after elopement accomplished for those residents found to have been affected by from the facility and not allowed to eat in the deficient practice? As it the main dining room. relates to Residents C, D, G and J, updated Elopement Risk Findings include: Assessments were completed on August 24, 2011 and are present on the medical record for each 1. The record for Resident #C was resident. In specific response to reviewed on 8/22/11 at 11:05 a.m. The the corrective actions resident's diagnoses included, but were accomplished for Resident C, we not limited to, depression, dementia, and offer the following: Resident C resumed meal service in the senile organic psychotic condition. The facility Main Dining Room as of resident was admitted to the facility on August 18, 2011. Effective 6/22/09. August 23, 2011, daily wellness visits with Resident C were initiated and will be completed for A nursing note, dated 7/24/11 at 2:50 a period of two weeks to ensure

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	155131		LDING	00	08/24/2011	
		100101	B. WIN		DDDDGG GITY GTATE 7ID GODE	00/2 1/2011	
NAME OF	PROVIDER OR SUPPLIEF	8		1	ADDRESS, CITY, STATE, ZIP CODE ALUMET AVENUE		
MUNSTI	ER MED-INN			1	ER, IN46321		
					EIX, 114-002 1		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETIO	NI.
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE	JΙΝ
1110	+	he nurse was "notified	+	1110	Resident C's psychosocial	Brite	
	1 * '				well-being is maintained. If t	here	
	`) was outside of facility			are no observed psychosocia		
	1	y herself. This writer			concerns, weekly wellness v		
	1	resident). Res (resident)			will be completed for a minin		
	`	d), skin w/d (warm/dry)."			of two additional weeks. If the then appears to be no obser	l l	
	The resident's vi	-			psycho-social concerns, rout	• • • • • • • • • • • • • • • • • • •	
	1 -	pulse 78, respirations 20,			Social Service visits will resu		
	1 -	are 126/60. There was no			on an as needed basis. The		
	acute distress no	ted. At 3:15 p.m., the			results of the visits will be		
	resident's skin cl	neck was completed with			documented in the Social Se progress notes. 2. How oth	l l	
	no bruising note	d. The resident indicated			residents having the potentia	• • • • • • • • • • • • • • • • • • •	
	she was in no pa	in. At 3:17 p.m., the			be affected by the same defi		
	physician was no	otified. At 3:20 p.m., the			practice will be identified and	• • • • • • • • • • • • • • • • • • •	
	resident's family	was notified. At (no			what corrective action(s) will	l l	
	1	new order was received			taken? As it relates to Reside	l l	
	1	rd. At 3:30 p.m., the			C, D, G, and J, as of August 2011, all facility residents we		
	1	s applied to the resident's			re-assessed for risk of elope	• • • • • • • • • • • • • • • • • • •	
	1	chair as ordered. At 6:00			through the use of our Elope		
		t had dinner in her room.			Risk Assessment Tool (see		
	1 -	e resident's family was			attached). Multi-disciplinary discussions were completed	for	
	_	p.m., the resident			the individuals who were	101	
	1 -	nderguard from her wrist.			identified as having risk for		
		s in her room in her			elopement. The family and		
	wheelchair watc				physician of all identified		
	wheelchan watc	ining television.			residents were contacted an		
	A	1.4. 1.7/25/11 .4.0.00			necessary interventions were discussed and implemented		
	1	dated 7/25/11 at 9:00			each individual resident effec	• • • • • • • • • • • • • • • • • • •	
	1 ' '	the wanderguard remains			August 25, 2011. For those		
		Res (resident) states she			residents identified as having	•	
	1	ollar Store next time its			risk for elopement warranting		
	1 ' '	(Resident) informed she			use of Wanderguard protecti Chain of Supervision plan wa	• • • • • • • • • • • • • • • • • • •	
	1	cility without staff or			implemented. As it relates to		
	1 -	5 p.m., the resident was			Resident C, the facility has		
	1 -	tray by a CNA. The			confirmed with Dietary staff t		
	resident was in h	er wheelchair and set up			there has been no change in	our	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155131 08/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **7935 CALUMET AVENUE** MUNSTER MED-INN MUNSTER, IN46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE to eat prior to CNA leaving the room. At Main Dining Room attendance as a result of any resident safety 12:45 p.m., the resident was at the nurse's concerns on the part of the station in wheelchair stating she did not facility. Furthermore, the facility have lunch and that her lunch was in the has reviewed all residents to ensure that there are no similar or bathroom. The CNA indicated the other restrictions in place due to resident was set by her bed and window safety concerns. 3. What and the resident moved the tray. The measures will be put into place or resident was ordered another lunch tray. what systemic changes will be made to ensure that the deficient practice does not recur? As it A nursing note, dated 7/26/11 at 6:30 relates to Resident C, D, G, and a.m., indicated, the resident was in her J, the facility reviewed and wheelchair in room, alert, verbally revised the Elopement Risk responsive, skin was warm and dry. She Assessment policy and procedure. All facility Social was informed to stay on the unit for Service staff were in-serviced meals. The resident verbalized regarding the revisions (see understanding. At 7:30 a.m., the resident attached). As it relates to Resident C, the facility has was up in her wheelchair attempting to go implemented the Chain of down to the main dining room for Supervision policy and procedure breakfast. Shed stated to writer, "I can do which will allow residents with the as I please and do you really think that I need for Wanderguard protection don't know what I'm doing, I know to have the necessary supervision, if they desire to exactly what I'm doing. I'll leave when I attend the Main Dining Room want to leave and (Roommate's name) is meal service. 4. How the staying upstairs (sic) with me." It was corrective action(s) will be explained to the resident why she was not monitored to ensure the deficient practice will not recur, i.e., what able to go downstairs. Resident calmed quality assurance program will be down and stated, "Oh whatever and said put into place? As it relates to alright." Residents C, D, G and J, effective August 24, 2011, the facility completed a review of every A nursing note, dated 7/27/11 at 3:00 residents chart and has verified p.m., indicated, the resident's the presence of an updated wanderguard to person was discontinued Elopement Risk Assessment and due to resident removal. At 11:30 a.m., ensured compliance with our policy on Elopement Risk the wanderguard to the resident's

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		DDIG	00	COMPL	ETED
		155131	A. BUI B. WIN	LDING		08/24/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	NAME OF PROVIDER OR SUPPLIER						
MUNICE				1	ALUMET AVENUE		
MUNSTER MED-INN				MONSI	ER, IN46321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	wheelchair was	in place.			Assessments. A Quality		
					Assurance Indicator has bee	en	
	A nursing note	dated 7/28/11 at 3:10			created to review a random		
	1	he resident was at the			sample of 20 residents per f		
	1 *				per month (yielding 100 aud per quarter) to assess for the		
		ranting to leave the facility			presence of a current Elope		
	~	e. The resident was			Risk Assessment, and to eva		
	redirected by sta	aff and Administrator was			the presence of and	aidato	
	made aware.				appropriateness of intervent	ions	
					and care planning based up	on	
	A nursing note	dated 8/7/11 at 4:30 p.m.,			the findings of the Elopemer	nt	
	_	ident indicated "she was			Risk Assessment. The Dire	ctor	
					of Social Service will be		
	1	sic) facility when she went			responsible for completing the		
	to activity. The	writer spoke with res			audit and will report findings		
	(resident) and in	formed her that she could			the Quality Assurance Comr	nittee	
	not leave the fac	ility without family or			on a quarterly basis for a minimum of one year. As it		
	staff. Res (resid	ent) got angry and went			relates to Resident C, the fa	cility	
	back to her roon	, ,			is committed to meeting on a	-	
	back to her room	1.			weekly basis for a minimum		
	.	1 . 10/15/11 . 7 45			weeks and monthly thereafte		
	1	dated 8/15/11 at 7:45			deemed appropriate) to revi	ew [`]	
	1	he resident was upset this			and discuss all residents		
	morning and too	k her breakfast tray and			identified as having a risk fo		
	put it on the floo	or in the middle of the			elopement and warrant the u		
	hallway. At 7:5	0 a.m., the nurse spoke to			of Wanderguard protection.		
	1	had her pick up the tray			will review the current dining		
		ay. The resident picked			arrangement for each reside requiring Wanderguard prote		
		-			to ensure that there has bee		
	the tray up and r	nanded it to the nurse.			change in dining service. Sl		
					a change be noted, it will be		
	A nursing note,	dated 8/18/11 at 2:30			necessary to provide the		
	p.m., indicated the resident's wanderguard				necessary documentation.		
	was discontinued and noted by social				Regardless of the reason, S		
	service. The resident's family was				Service will provide an initial		
		-			well-check visit (additional v		
	informed. At 2:40 p.m., MDT (Multidisciplinary Team) discussion today				may be necessary and will b		
	1 ` *	,			documented as such in the		
	regarding wande	erguard. The resident and			Service section of the medic	al	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	155131	A. BUI	LDING	00	COMPL 08/24/2	
		100101	B. WIN			00/24/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MUNISTE	ER MED-INN				ALUMET AVENUE TER, IN46321		
					ER, 1140321		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
1710	family requested	· · · · · · · · · · · · · · · · · · ·	-	1710	record) with the resident to		DATE
		sident stated, "She will			ensure that there are no		
		lity unattended, states			psycho-social impacts as a r		
		go to dining room for			of the change and will report	any	
		to attend activities.			concerns to The Director of Social Service or		
		vanderguard should be			Administration. 5. By what	date	
		ime. Resident Education			will the systemic changes be		
	done at this time.				completed? August 25, 201	1	
	uone at tins time.						
	A Davishiatmy mat	a datad 0/11/11					
	A Psychiatry not	atient) seated in room.					
	, 4	<i>'</i>					
		er the incident when she					
	-	to Target. She said she					
		couldn't go stating 'I used					
	-	nd the Dollar Store with					
	*	said '5 minutes more					
	` ′ •	have never known.' She					
		n I would not do it again.					
	•	hildish about it. It makes					
	me want to do so	_					
		ist now be restricted as a					
		action. She was not					
		She did laugh about it					
	"	out it in order to lighten					
	_	She brought up her					
		were alive. Her memory					
	was impaired. Sl						
	_	her wheelchair. She					
	reportedly cut the	e one off her arm."					
		5					
	A quarterly Mini						
	· ·	ed 7/21/11, indicated she					
		and she understands. She					
	scored an eleven	out of fifteen on the					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155131			LDING	00	COMPL 08/24/2	ETED	
	PROVIDER OR SUPPLIEI	<u> </u>	B. WIN	7935 C	DDRESS, CITY, STATE, ZIP CODE ALUMET AVENUE ER, IN46321	<u> </u>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIATE		ΤΕ	(X5) COMPLETION DATE
	BIMS (Brief Int which indicated impaired cognition the correct year accurate to the mand she was able words given at it assessment with cueing for the serecall the third was a discovered with the serecal that the serecal that the third was a discovered with the serecal that the serecal that the serecal that more impairment. Should be serecally the following and month. She of the following city, hospital, and out of five when "WORLD" back items to recall shall the items. She continues the serecal shall the items. She continues the serecal shall the serecal shall assessment and a wanderguate. There were no of the following city.	she was moderately vely. The resident missed by one year, she was nonth within five days, at to recall one of the three the beginning of the no cueing, she needed word, and could not word. State Examination 7/25/11, indicated a score which would indicate the derate cognitive answered correctly two asswered correctly two asswered correctly two asswered correctly two asswered to spell the word wards. When given three the could only recall one of ould not copy a figure of					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155131	A. BUILDING	00	COMPLETED 08/24/2011
		100101	B. WING		00/24/2011
NAME OF I	PROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE	
MUNSTE	R MED-INN		l l	ALUMET AVENUE FER, IN46321	
(X4) ID		TATEMENT OF DEFICIENCIES	I ID	,	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	A care plan, initi	ated on 7/24/11, indicated			
	a problem of exit	ting the facility alone.			
	The approaches i	included, but were not			
	limited to, remin	ding the resident it was			
	dangerous to exit	t the building alone,			
	wanderguard on	bottom of wheelchair due			
	to resident remov	ving the wanderguard			
	from her wrist, c	heck wanderguard			
	placement, and n	notify physician of any			
	new orders.				
		note, dated 7/25/11,			
		it was noted outside the			
	facility and off p				
		ing went to get the			
		rned her to the facility			
		The resident indicated she			
		pping and later indicated			
	· ·	for a walk and was tired			
	of being inside.				
		anderguard. The resident			
	later removed the	e wanderguard to wrist			
	and				
		wheelchair was applied.			
	•	ussed situation and safety			
		e resident and she stated			
		nen she wants to. In			
	morning meeting				
		niting resident's activity			
	_	acility until resident safety			
		essed. Social Service			
		ly meeting and family			
		ff at this time. The			
	family was in ag	reement with facility			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE COMPL		
AND PLAN	OF CORRECTION	155131	A. BUI	LDING	00	08/24/2	
		100101	B. WIN		DDDDGG GITTY GTATE ZID GODE	00/24/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE ALUMET AVENUE		
MUNSTE	ER MED-INN			1	ER, IN46321		
(X4) ID		TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
	attempts to keep	resident safe with					
	wanderguard, and	d limiting activities.					
	Family indicated	they visited yesterday					
	and discussed co	ncerns with the resident.					
	The family indicate	ated they will attempt to					
	take the resident	out on pass with family					
	1 -	ner permits. Social					
		resident and discussed					
		resident had some					
		ted difficulty with word					
	finding.						
		note, dated 7/26/11,					
		dent continues to exhibit					
	_	sion and resident having					
	1	ord finding and becomes					
		versation at times. A new					
		ed to start Namenda (used					
	to treat moderate	to severe dementia).					
	A social service i	note, dated 8/16/11,					
		service was informed by					
		was upset and requesting					
		removed. Resident had					
	1	eals at times. The					
	ı	cement was discussed					
		mily. The family was					
	informed of risks	-					
		explained facility desire					
	1	ent's independence and					
	dignity. The con	cerns of the resident					
	refusing meals ar	nd the concern of the					
	wanderguard hav	ring a negative affect on					
	the resident were	discussed. The resident					

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l l		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155131	B. WIN	IG		08/24/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	-	
					ALUMET AVENUE		
MUNSTE	R MED-INN			MUNST	ER, IN46321		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		l not leave the facility					
	~	and stated to social					
	*	e wishes she would not					
	have left. The fa	mily feels the resident					
	will not attempt t	to leave the facility again					
	and was remorse	ful about the situation.					
	Family would lik	te the wanderguard					
	removed.						
	A social service i	note, dated 8/18/11,					
	indicated MDT a	nd Psychiatrist discussed					
		ce the removal of the					
	wanderguard. Re	esident and family want					
	_	removed. After further					
	·	feels that wanderguard					
		ed at this time. The					
		cated on safety of not					
		ing unattended. The					
	~						
	resident agrees a	ild uliderstallds.					
ı	Interview with C	ocial Service #1 on					
		p.m., indicated the most					
		t Risk Assessment for					
		6/22/09. She further					
		s the staff member who					
		pleted the assessments					
	and there were no	o other assessments.					
		ne Administrator on					
		p.m., indicated the					
	ground floor doo						
	wanderguard ala	rm. The resident was not					
	kept from the ma	in dining room due to the					
	wanderguard it w	vas due to the staff					

000056

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155131	A. BUI	LDING	00	COMPL 08/24/2	
		100101	B. WIN			00/24/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MUNSTE	R MED-INN			1	ALUMET AVENUE FER, IN46321		
					1		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
		esident's behavior and her					
		as still going to leave. It					
		ed with her stating she					
		ve and the doors not					
		y the wanderguard					
	· -	t in the best interest of					
	*	ep her on the unit to					
		vior. The resident was					
	allowed to come						
		ne was receiving her					
	meals on the unit	_					
	Interview with th	e Director of Nursing					
		or on 8/22/11 at 2:30					
	p.m., indicated sl	ne thought the resident's					
	wanderguard from	_					
	discontinued in J	anuary 2010. It was					
	indicated the resi	dent left the facility					
	because she was	angry her roommate					
	would not be in t	he facility for the activity					
	they had planned	to do together and her					
		oing out with her family.					
	· -	licated the roommate's					
	family will at tim	nes take Resident #C out					
	with them when	they go out. It was then					
	indicated Resider	nt #C had come along					
	way from when s	she first came to the					
	facility with her	behaviors. Resident #C					
	was also very ter	ritorial. It was also					
	indicated when the	he resident would get on					
	the elevator and l	her wanderguard would					
	sound she would	say, "That's me."					
	Interview with th	e current Second Floor					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION 00	COMPI	
		155131	A. BUI B. WIN	LDING IG		08/24/2	011
		1	p. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIE	R			ALUMET AVENUE		
	ER MED-INN			1	ER, IN46321		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	ŧ	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	"	he new Second Floor Unit					
	Manager, Social						
	Administrator, a						
		n 8/22/11 at 3:45 p.m.,					
		sident was a focused					
		was to have periodical					
		cks being completed after					
		d was discontinued. It was					
		I that this meant checking					
		luring the day and					
	_	t night. The resident was					
		lay so the checking was					
	_	he facility did not indicate					
		ne checking on the					
		requency of the checks. It					
		ed the resident was having					
		ot eating due to the					
		nd being monitored on the					
		indicated the resident not					
	1 -	r wanderguard, but was					
	1	ke the wanderguard off of					
		It was thought that in the					
		he resident and to give the					
	_	idence the wanderguard					
		ntinued. There were no					
		ons indicated after the					
	1	as discontinued. It was					
		at the resident wanted her					
	_	nd did not like staff being					
	with her all of the	ne time.					
	Interview with S	Social Service #1 on					
		a.m., indicated she spoke					
	to the resident n	nultiple times. The					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7G4011

Facility ID:

000056

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155131	B. WIN			08/24/2	011
		1	D. WII		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	ALUMET AVENUE		
MUNSTE	ER MED-INN			1	ER, IN46321		
		OTATE MENT OF DEFICIENCIES					ars)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	†	come to her office on the	1				
		ner, but she was not sure					
		·					
		ed the visits. She					
	indicated she do	es monthly					
	documentation.						
		he Assistant Administrator					
	and the Director	of Nursing on 8/24/11 at					
	11:45 a.m., indic	cated they would see if					
	there was any do	ocumentation of social					
	service visits for	the resident when she					
	was restricted to	the unit for meals.					
	During the exit i	nterview on 8/24/11 at					
	1	was no additional					
		vided related to social					
	1						
	_	with the resident after she					
	was restricted to	her unit for meals.					
	2 The record for	or Resident #J was					
		3/11 at 11:40 a.m. The					
		oses included, but was not					
	1	osis, advanced organic					
		and dementia with					
	behavioral distu	rbances. The resident was					
	admitted to the f	acility on 3/19/10.					
	A nursing note,	dated 8/9/11 at 10:20					
	p.m., indicated the	he resident was					
	1 *	nit and slight agitation					
	was noted.	5 5					
	An Elonement R	Lisk Assessment, dated					
	_	ed the resident was at risk					
	1 3/17/10, indicate	a me resident was at risk					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED 08/24/2011
		155131	B. WING		06/24/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
MUNSTE	ER MED-INN			CALUMET AVENUE TER, IN46321	
				1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE DATE
	for elopement an	d was residing on the			
	secured unit and a wanderguard was				
	ordered.	C			
	There were no ot	her Elopement Risk			
	Assessments in t	he resident's record.			
	A care plan, initia	ated on 12/7/10 and			
	updated 3/1/11 ar	nd 5/3/11, indicated a			
	•	ering. The resident			
	_	s and other resident's			
		can become exit seeking			
		proaches included, but			
		to, providing a safe			
		a wanderguard in place,			
		outs often, and encourage			
	activity participa	tion.			
	Torrest to tale at				
		ne Assistant Administrator			
		of Nursing on 8/23/11 at ted there were no other			
	• •	Assessments completed			
	-	a resident was admitted			
	to the facility.	a resident was admitted			
	to the facility.				
	3. The record for	r Resident #G was			
		2/11 at 3:20 p.m. The			
		ses included, but was not			
	_	ssion, cerebrovascular			
	-	unusual behaviors, and			
	· ·	esident was admitted to			
	the facility on 7/2				
	,				
	The resident plan	of care card indicated			

Facility ID:

PRINTED: 08/31/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131		A. BUI	LDING	NSTRUCTION 00	(X3) DATE : COMPL 08/24/2	ETED	
		155151	B. WIN		DDDEGG GITTY GTATE ZID GODE	06/24/2	011
NAME OF	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE ALUMET AVENUE		
MUNSTE	ER MED-INN				ER, IN46321		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1	to have a wanderguard on					
	his chair and on his right arm.						
	A care plan initi	ated on 11/18/10 and					
	1 .	/11, 5/1/11, 7/27/11, and					
	1 ^	l a problem of resident					
	1	rd in place due to a					
		ering. The approaches					
	1 -	ere not limited to,					
	1	place at all times,					
	encourage invol	*					
	1	ot to keep resident					
	1	rtive visits from family to					
	assist with shopp	oing desires, and activities					
	to continue to as	sist with shopping when					
	weather permits.						
	1 1	tisk Assessment, dated					
	1	ed this was an initial					
		the resident was not at					
	risk for elopeme	nt.					
	There						
	1	her Elopement Risk					
	Assessments in 1	the resident's record.					
	Interview with the	ne Assistant Administrator					
		of Nursing on 8/23/11 at					
		ated there were no other					
	_	Assessments completed					
	_	a resident was admitted					
	to the facility.						
	4. The record for	or Resident #D was					
	reviewed on 8/2	2/11 at 5:30 p.m. The					

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Event ID: 7G4011

Facility ID:

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED	
		155131	B. WIN			08/24/2011	
			P. (12)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	S.		1	ALUMET AVENUE		
MUNSTE	ER MED-INN			1	ER, IN46321		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	1	ID		(X5)	
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETIO	N N
TAG	.	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
		ses included, but were	i				
	ı	epression, and dementia					
		disturbances. The					
		nitted to the facility on					
	11/6/09.						
	I	sician Order Statement					
	for August of 20						
	wanderguard was	s to be on the resident's					
	wheelchair.						
	Review of the res	sident's plan of care card					
	did not indicate t	he resident had a					
	wanderguard.						
	_						
	Review of the res	sident's care plans did not					
		related to the resident					
	1	k for elopement or for the					
	resident to have a	_					
	resident to nave t	a wandergaara.					
	Review of an Elo	onement Risk					
		ed 11/6/09, indicated the					
	resident was not	at risk for elopement.					
	There were me at	thar Elanamant Diale					
		ther Elopement Risk					
	Assessments in t	he resident's record.					
	Internia 34 C	anial Campian Wind an an					
		ocial Service Worker on					
		18/24/11 at 9:15 a.m.,					
	_	nent Risk Assessments					
	_	leted quarterly, annually					
	1	in condition. She					
	indicated the asso	essments were					
	implemented yes	sterday and there was no					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE S COMPL		
ANDILAN	OF CORRECTION	155131	A. BUII			08/24/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	ALUMET AVENUE		
MUNSTE	ER MED-INN			1	ER, IN46321		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	1	Risk Assessment for					
	Resident #D after						
	5. The Elopemen	t Risk Assessment Policy					
	was provided by	the Administrator on					
	8/22/11 at 2:40 p	.m. The Social Service					
	Department was	responsible for the					
	procedure. The p	purpose: "To					
	appropriately ide	entify those at risk for					
	elopement." The	procedure included, but					
	was not limited to	o, the following: "1.0					
	All new admission	ons will be assessed by					
		uring the completion of					
	l .	y." "2.0 All other					
	residents will be	assessed by Social					
		ss of past "no" risk scores					
		cognitive or behavioral					
	status or when a	_					
		d. 3.0 Social Service					
	_	onitor, and update care					
	^	eed for elopement					
		4.0 All residents will					
	be assessed annu	ally."					
	Interview with th	ne Assistant Administrator					
	and the Director	of Nursing on 8/23/11 at					
		ted there were no other					
	_	Assessments completed					
	other than when	a resident was admitted					
	to the facility. W	hen wanderguards were					
	placed on resider	nts it was done by Social					
	Services and per	policy Elopement Risk					
	Assessments sho	uld have been done					
	annually and wer	re not. The facility was in					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
	or condition.	155131	A. BUILI B. WING			08/24/20	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVENUE MUNSTER, IN46321				
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	I	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	Ē	(X5) COMPLETION
TAG	the process of as elopement risk an updating their po indication as to w not completing th Risk Assessment	sessing all residents for and the facility was licy. There was now hy social service were an annual Elopement s.		TAG	DEFICIENCY)		DATE
F0323 SS=J	environment rema hazards as is poss receives adequate devices to prevent Based on observa interview, the fac interventions wer supervision of a refailed to assess the risk of elopement prior to removing 4 residents review	ation, record review and cility failed to ensure	F03	323	F-323 Submission of this response and Plan of Correctis not legal admission that a deficiency exists, or that a Statement of Deficiency was correctly cited. Submission of this response is not to be construed as an admission of deficiency against the facility Administrator, or any employ who draft or may be discussed this response and Plan of Correction. In direct response	of f any , the ees ed in	08/25/2011

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Event ID:

7G4011

Facility ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155131	A. BUI	LDING	00	08/24/2	
		199191	B. WIN			00/24/2	011
NAME OF	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
MUNICT	D MED INN			1	ALUMET AVENUE		
MUNSTE	ER MED-INN			MONST	ER, IN46321		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	·		DATE
		eopardy began on 8/18/11			the five questions listed on p two of Kim Rhoades, Directo		
	_	ent assessment was			Long Term Care, letter to this		
	1 -	vanderguards were			facility dated August 26, 201		
	discontinued for	a resident with a history			facility offers the following:1.		
	of elopement. T	The Executive Director,			What corrective action(s) will		
	Administrator, A	Assistant Administrator			accomplished for those resid		
	and Director of	Nursing were notified of			found to have been affected the deficient practice? As it	υy	
	the immediate je	eopardy at 4:30 p.m. on			relates to Resident C, upon		
		mediate jeopardy was not			notification of the concern or	the	
		exit date of the survey.			part of the Indiana State		
		,			Department of Health, the fa	, ,	
	Findings include	··			took immediate action which included every 30 minute		
	I manigo merado	•			documented checks for this		
	Resident #C was	s observed on 8/22/11 at			resident's whereabouts. The	ese	
		etivities on the second			checks were in place until Au	ıgust	
		NGO. There was no			25, 2011 when Resident C's		
	1				Chain of Supervision plan wa implemented. An updated	as	
	wanderguard on	her or on her wheelchair.			Elopement Risk Assessment	was	
	0 0/22/11 + 16	N 15 P : 1 4 // G			completed for Resident C an		
		2:15 p.m., Resident #C			determined the resident to be		
		the ground floor in the			risk for elopement. Given the		
	_	m eating lunch. There			previous elopement and thes		
	·	uard observed on her or			findings, we communicated the resident, her family and	VILII	
	on her wheelcha	ir.			physician the need to re-app	lv a	
					wanderguard bracelet for safe	-	
	On 8/22/11 at 3:	20 p.m., Resident #C was			All parties were in agreemen		
	observed self pro	opelling her wheelchair			Daily wellness visits with Res		
	on the ground fl	oor from activities to the			C will be completed for a per of two weeks to ensure Resi		
	elevator. She ste	opped her wheelchair			C's psychosocial well-being		
		esident and was waiting			maintained. If there are no		
	with several other	er residents in the			observed psychosocial conc		
	hallway. Staff v	vere observed in the			weekly wellness visits will be		
	hallway with the				completed for a minimum of additional weeks. If there the		
					appears to be no observable		
	The record for R	Resident #C was reviewed			psycho-social concerns, rout		
	I THE TECOTO IOI I	Condent #C was ICVICWCU					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155131 08/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **7935 CALUMET AVENUE** MUNSTER MED-INN MUNSTER, IN46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE on 8/22/11 at 11:05 a.m. The resident's Social Service visits will resume on an as needed basis. The diagnoses included, but were not limited results of the visits will be to, depression, dementia, and senile documented in the Social Service organic psychotic condition. The resident progress notes. The facility developed a Chain of Supervision was admitted to the facility on 6/22/09. policy and procedure to ensure appropriate supervision of A nursing note, dated 7/12/11 at 11:30 residents with orders for a.m., indicated the resident had increased Wanderguard protection (See confusion and went into another resident's attached). Staff training and in-service education was provided room, she was soaking wet and yelling out regarding the Chain of at this resident. The resident was Supervision policy and procedure redirected to go to her room and the nurse to ensure the necessary would come and help her. At 12:00 p.m., supervision and that resident safety is maintained while off of the resident was changed and remained the nursing unit. The Chain of up. The resident was reassured that staff Supervision policy and procedure were there to take care of her. She wanted requires that prior to Resident C leaving the nursing unit, she be her roommate to change her clothes. The accompanied by family or a staff nurse informed her staff was here for that member. The plan requires that and the roommate could not help her. the resident be signed off the unit with the current date and time as A nursing note, dated 7/24/11 at 2:50 well as with a notation of the expected time of her return. The p.m., indicated the nurse was "notified individual who signs the resident that res (resident) was outside of facility out will assume responsibility for off of property by herself. This writer her supervision from the assigned went to get res (resident). Res (resident) nurse on the nursing unit and the assigned nurse will co-sign to a/o (alert/oriented), skin w/d (warm/dry)." indicate her awareness of the The resident's vital signs were resident's whereabouts. The temperature 98, pulse 78, respirations 20, individual who has signed the and blood pressure 126/60. There was no resident off the unit shall be responsible for ensuring direct acute distress noted. At 3:15 p.m., the supervision of the resident for resident's skin check was completed with duration of time that she is off the no bruising noted. The resident indicated unit. Upon the residents return to she was in no pain. At 3:17 p.m., the the unit, it will be necessary for both the person returning the physician was notified. At 3:20 p.m., the

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155131	B. WIN			08/24/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ALUMET AVENUE		
MUNSTE	ER MED-INN			1	ΓER, IN46321		
			_		,		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
TAG	· `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	E COMPLETIO DATE	JIN
IAU		· · · · · · · · · · · · · · · · · · ·	+	IAU	resident to the unit and the	DATE	
	1	was notified. At (no			assigned nurse to document	the	
	· /	new order was received			time of her return and sign th		
		d. At 3:30 p.m., the			the nurse again resumes the		
	wanderguard was	s applied to the resident's			responsibility for the resident	's	
	wrist and wheelc	hair as ordered. At 6:00			supervision. As of August 25		
	p.m., the resident	t had dinner in her room.			2011, all of our staff have be		
	At 6:10 p.m., the	resident's family was			formally in-serviced with the exception of vacationing staf		
	1 * '	p.m., the resident			those on a leave of absence		
	_	nderguard from her wrist.			Staff on vacation or leave of		
		in her room in her			absence have been advised	they	
					may not return to duty until the	ney	
	wheelchair watch	ing television.			are in-serviced on the Chain	of	
					Supervision policy and		
	I -	lated 7/25/11 at 9:00			procedure. 2. How other	l to	
	a.m., indicated, t	he wanderguard remains			residents having the potential be affected by the same defi		
	to wheelchair. "	Res (resident) states she			practice will be identified and		
	is going to the D	ollar Store next time its			what corrective action(s) will		
	(sic) closer. Res	(Resident) informed she			taken? As of August 24, 201	1, all	
	is not to leave fac	cility without staff or			facility residents were		
		5 p.m., the resident was			re-assessed for risk of elope		
	I -	ray by a CNA. The			through the use of our Elope Risk Assessment Tool (see	ment	
	l -	er wheelchair and set up			attached). Multi-disciplinary		
		-			discussions were completed	for	
	_	NA leaving the room. At			the individuals who were		
	_	esident was at the nurse's			identified as having risk for		
		eelchair stating she did			elopement. The family and		
		nd that her lunch was in			physician of newly identified		
	the bathroom. T	he CNA indicated the			residents were contacted an		
	resident was set l	by her bed and window			necessary interventions were discussed and implemented		
	and the resident	moved the tray. The			each individual resident effec		
	resident was orde	ered another lunch tray.			August 25, 2011. For those		
		-			residents identified as having	·	
	A nursing note of	lated 7/26/11 at 6:30			risk for elopement warranting		
	I -	he resident was in her			use of Wanderguard protecti		
	1	om, alert, verbally			Chain of Supervision plan (a detailed above) was engage		
		•			What measures will be put in		
	responsive, skin	was warm and dry. She			Will be put if		

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	IULTIPLE CON	NSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	ILDING	00	COMPLETED	
		155131	B. WIN			08/24/2011	
			B. WII		DDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R					
MUNICTE	ER MED-INN				ALUMET AVENUE ER, IN46321		
MONSTE	EK MED-IMM			MONST	ER, 11140321		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FUL	L	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETIC	ON
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATIO	N)	TAG	DEFICIENCY)	DATE	
	was informed to	stay on the unit for			place or what systemic chan	ges	
	meals. The resid	dent verbalized			will be made to ensure that t	he	
		At 7:30 a.m., the resident			deficient practice does not		
	1				recur? The measures which		
	1 -	heelchair attempting to go			put into place to ensure that		
	1	n dining room for			type of occurrence does not		
	breakfast. Shed	stated to writer, "I can do			involve several steps including	- 1	
	as I please and d	lo you really think that I			the review and revision of fac Elopement Risk Assessment		
	1 -	t I'm doing, I know			policy and procedure. All fac		
	1	doing. I'll leave when I			Social Service staff were	,iiity	
	1 *	•			in-serviced regarding the		
		d (Roommate's name) is			revisions (see attached). The		
	staying upstairs	(sic) with me." It was			facility is committed to meeti		
	explained to the	resident why she was not			a weekly basis for a minimur		
	able to go down	stairs. Resident calmed			12 weeks and monthly there	after	
	1 -	, "Oh whatever and said			(if deemed appropriate) to re	view	
		, On whatever and said			and discuss all residents		
	alright."				identified as having a risk for		
					elopement and warrant the u	se	
	A nursing note,	dated 7/27/11 at 3:00			of Wanderguard protection.		
	p.m., indicated t	he resident's wanderguard			During these meetings, the C		
	_	scontinued due to residen	I .		of Supervision documentatio		
	1 -	30 a.m., the wanderguard			be reviewed to ensure prope	r	
		•			completion and accuracy.		
	to the resident's	wheelchair was in place.			Additionally, during these meetings, a review of care		
					planning and interventions w	hich	
	A nursing note,	dated 7/28/11 at 3:10 p.m.			are in place will be reviewed		
	indicated, the re	sident was at the nurse's			discussed to ensure the		
		to leave the facility to go			effectiveness of the care plan	n in	
	_	e resident was redirected			place. The facility posted sig		
					at all ground floor exits urgin		
	1 -	ninistrator was made			visitors to take caution when		
	1	p.m., activities will take			entering and exiting the facili	ty to	
	the resident out	tomorrow.			ensure that unaccompanied		
	1				residents do not exit with the	m	
	A nursing note	dated 8/7/11 at 4:30 p.m.,			and requesting that if such		
	1	sident said "she was going			observation be made, the vis	sitor	
					immediately report to a staff	11	
	1	cility when she went to			member. The facility has add	iea,	
	activity. The wi	riter spoke with res			as a part of our admission		
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLET	ED
		155131	B. WIN			08/24/201	1
					DDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIE	R		1	LUMET AVENUE		
MUNSTE	ER MED-INN			1	ER, IN46321		
		CTATEMENT OF DEFICIENCIES		ID	,		(V5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	re '	DATE
1710		formed her that she could	-	1710	process, a notice to all new		DITTE
	` ′				families to be cautious when		
		ility without family or			entering and exiting the facili	ty to	
	,	ent) got angry and went			ensure that unaccompanied	·	
	back to her roon	n."			residents do not exit with the	m	
					and informing them to		
	A nursing note,	dated 8/15/11 at 7:45			immediately report to staff ar		
	a.m., indicated t	he resident was upset this			such observations. The facil will require, prior to the	ity	
	· ·	ok her breakfast tray and			discontinuation of any		
	_	or in the middle of the			Wanderguard protection, tha	ta	
	1 ^	0 a.m., the nurse spoke to			multi-disciplinary team meeti		
	1 *	had her pick up the tray			be completed including the		
					resident/family and physiciar		
		ay. The resident picked			discuss the appropriateness		
	the tray up and h	nanded it to the nurse.			removal, discussion of care p		
					development and the initiation appropriate alternate	on or	
	A nursing note,	dated 8/18/11 at 2:30			interventions (where applical	ole)	
	p.m., indicated t	he resident's wanderguard			An updated Elopement Risk	,.	
	was discontinue	d and noted by social			Assessment shall be comple	ted	
		ident's family was			and would reflect whatever		
	informed. At 2:	•			change has occurred prompt		
		ry Team) discussion today			the removal of the Wandergu		
	1	erguard. The resident and			protection. Documentation or rationale supporting the remo		
	1 ~ ~	· ·			along with notation of the	Jvai	
	1 * *	l wanderguard be			discussion occurring in the		
		esident stated, "She will			multi-disciplinary team meeti	ng	
		eility unattended, states			will be retained in the resider	nt's	
	she would like to	o go to dining room for			medical record (see		
	meals and wants	s to attend activities.			attached). The facility has		
	MDT feels that	wanderguard should be			included our Chain of Superv		
		time. Resident education			policy and procedure as a to General Orientation which is	pic III	
	done at this time				presented to all newly hired	staff.	
					The facility is committed to		
	A Povohiotry no	te_dated 7/13/11			conducting semi-annual		
	A Psychiatry note, dated 7/13/11, indicated "I reviewed the nursing notes				in-servicing to all staff regard		
		•			facility elopement and the Ch	nain	
	over the last month and no sleeping				of Supervision policy and		
	problems are rep	ported. The resident			procedure. The facility has		
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	7G4011	Facility II	D: 000056 If continuation sl	heet Page	31 of 43

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155131 08/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **7935 CALUMET AVENUE** MUNSTER MED-INN MUNSTER, IN46321 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE urinated on self and per nursing report engaged our Wanderguard representative in assisting with was observed using foul language because the assessment and evaluation of her roommate wouldn't help her change options to further secure all her clothing. I continue charting on her facility ground floor entrances and exits with additional Wanderguard behaviors. She is not on the prn (as protection. To clarify, all exits on needed) Seroquel (anti-psychotic) stated the ground floor are currently key earlier this year for behavioral issues." pad locked and require the entry Addendum: The activity staff reported of a posted six (6) digit code to the resident was having memory open the doors.4. How the corrective action(s) will be problems, not able to play BINGO as monitored to ensure the deficient before. She expects her roommate to help practice will not recur, i.e., what her and becomes angry. Resident to have quality assurance program will be urine checked and if no infection restart put into place? Effective August 24, 2011, facility completed a prn Seroquel." review of every resident's chart and has verified the presence of A Psychiatry note, dated 8/11/11, an updated Elopement Risk indicated, "Pt (patient) seated in room. Assessment and to ensure compliance with our policy on Discussed with her the incident when she Elopement Risk Assessment. A left facility to go to Target. She said she Quality Assurance Indicator has didn't know she couldn't go stating 'I used been created to review a random to go to Target and the Dollar Store with sample of 20 residents per floor per month (yielding 100 audits my mother.' She said '5 minutes more per quarter) to assess for the (sic) they would have never known.' She presence of a current Elopement stated 'I told them I would not do it again. Risk Assessment, and to evaluate They are being childish about it. It makes the presence of and appropriateness of interventions me want to do something else.' I and care planning based upon explained she must now be restricted as a the findings of the Elopement result of her own action. She was not Risk Assessment. The Director accepting of this. She did laugh about it of Social Service will be responsible for completing this when I joked about it in order to lighten audit and will report findings to up the moment. She brought up her the Quality Assurance Committee mother as if she were alive. Her memory on a quarterly basis for a was impaired. She now has a minimum of one year. 5. By what date will the systemic changes be wanderguard on her wheelchair. She Facility ID:

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Event ID:

7G4011

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155131		LDING	00	08/24/2	
		100101	B. WIN		DDDEGG CITY CTATE ZIR CODE	00/24/2	011
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	ADDRESS, CITY, STATE, ZIP CODE		
MUNSTE	ER MED-INN			1	ER, IN46321		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	reportedly cut th	e one off her arm."			completed? August 25, 201	I	
	A quarterly Min						
		ed 7/21/11, indicated she					
		and she understands. She					
		out of fifteen on the					
	`	erview for Mental Status)					
		she was moderately					
	1 ^	vely. The resident					
	1	ct year by one year, she					
		the month within five					
	1 - 1	as able to recall one of the					
		en at the beginning of the					
		no cueing, she needed					
	_ ~	econd word, and could not					
	recall the third w	vord.					
		State Examination					
	` ''	7/25/11, indicated a score					
		which would indicate the					
	resident had mo	derate cognitive					
	impairment. She	e answered correctly two					
	1	: year, season, date, day,					
	and month. She	answered correctly two					
	_	: state, country, town or					
	1	d floor. She scored a two					
		asked to spell the word					
		wards. When given three					
		ne could only recall one of					
		ould not copy a figure of					
	intersecting pent	agons.					
	The resident's n	an of care card indicated					
		to have a wanderguard on					
	L are resident was	to have a wanderguard on					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155131			LDING	00	COMPL	
		155131	B. WIN	IG		08/24/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ALUMET AVENUE		
MUNSTE	R MED-INN			MUNST	ER, IN46321		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	her wheelchair.						
	_	isk Assessment, dated					
	· ·	d this was an initial					
	assessment and the	he resident was at risk					
	and a wandergua	rd was in place.					
	There were no ot	her Elopement Risk					
	Assessments in the	he resident's record.					
	A care plan, initia	ated on 7/24/11, indicated					
	a problem of exit	ting the facility alone.					
		included, but were not					
	_ ^ ^	ding the resident it was					
		t the building alone,					
	_	bottom of wheelchair due					
	"	ving the wanderguard					
		heck wanderguard					
	· ·	otify physician of any					
	new orders.	oury physician or any					
	new orders.						
	A	1.4. 1.7/20/11					
		note, dated 7/20/11,					
		dent was alert and					
		vo with confusion. There					
		aviors present over the					
	l	The resident was seen by					
	1	on 7/13/11 and received					
	a new order for S	Seroquel (anti-psychotic)					
	as needed due to	agitation.					
	A social service i	note, dated 7/25/11,					
	indicated the resi	dent was noted outside					
	the facility and o	ff property without					
	1	ing went to get the					

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	ĺ	LDING	NSTRUCTION 00	(X3) DATE S COMPL 08/24/2	ETED
	PROVIDER OR SUPPLIER		·	7935 CA	DDRESS, CITY, STATE, ZIP CODE ALUMET AVENUE ER, IN46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	with no injury. Wanted to go she wanted to go she she wanted to go of being inside. received for a walater removed the and a wanderguard to Nursing has disc concerns with the she will leave who morning meeting and limiting resident facility until better assessed. a family meeting hold off at this tragreement with fresident safe with limiting activitie visited yesterday with the resident they will attempt on pass with fampermits. Social sand discussed co had some confus with word finding						
	indicated the resi	note, dated 7/26/11, ident continues to exhibit sion and resident having ord finding and becomes					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155131	A. BUI	LDING	00	08/24/2	
		130101	B. WIN			00/24/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
MUNSTE	R MED-INN			1	ALUMET AVENUE TER, IN46321		
		TATEMENT OF DEFICIENCIES					(7/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	frustrated in conv	versation at times. A new					
		ed to start Namenda (used					
		to severe dementia).					
		to be vere demonday.					
	A social service 1	note, dated 8/16/11,					
		service was informed by					
		ent was upset and					
		erguard be removed.					
		n refusing meals at					
		lerguard placement was					
		IDT and family. The					
		med of risks of removing					
	1 *	explained facility desire					
	_	ent's independence and					
		cerns of the resident					
		nd the concern of the					
		ring a negative affect on					
		discussed. The resident					
	indicated she wil	l not leave the facility					
		and stated to social					
	I -	wishes she would not					
	*	mily feels the resident					
		to leave the facility again					
	_	ful about the situation.					
	Family would lik	te the wanderguard					
	removed.	Č					
	A social service i	note, dated 8/18/11,					
	indicated MDT a	nd Psychiatrist discussed					
		ce the removal of the					
	wanderguard. Re	esident and family want					
		removed. After further					
	discussion, MDT	feels that wanderguard					
		ed at this time. The					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155131		A. BUI	LDING	00	COMPL 08/24/2	
		100101	B. WIN			00/24/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
MUNISTE	ER MED-INN			1	ALUMET AVENUE FER, IN46321		
				ļ.,,	ER, 11140321		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		cated on safety of not	+	1110			Ditte
		ing unattended. The					
	resident agrees a	•					
	resident agrees a	nd understands.					
	Review of a reno	ortable incident on					
	1	.m., indicated on July 24,					
	_	., staff was made aware					
	_	y member that Resident					
	-	at the adjacent shopping					
		ng the video footage the					
		ie building through the					
		elchair at 1:58 p.m. The					
	1 ^	the parking lot to the					
		sidewalk and proceeded					
		the strip mall. At 2:39					
		red and the resident was					
	1 *	icility without injury at					
	2:49 p.m.	cinty without injury at					
	2.49 p.m.						
	A Memo to the I	ndiana State Department					
		7/28/11, indicated "To					
	· ·	mstance, staff was made					
		mmate's family that					
	1 *	ame) was observed					
	`	,					
	· ·						
	^						
		_					
		•					
	`	· •					
	entering the adjact reviewing the vice #C's name) exited the patio doors in approximately 1: assistance of ano (Resident #C's nawheelchair acrost the sidewalk and	cent shopping center. In deo footage, (Resident d the building through a her wheelchair at 58 p.m., with the ther resident's spouse. The parking lot up onto to the store. At 2:39 (C's name) nurse exited					

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Event ID:

7G4011

Facility ID:

000056

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155131		<u> </u>	LDING	NSTRUCTION 00	(X3) DATE S COMPL 08/24/2	ETED	
	PROVIDER OR SUPPLIER	!		7935 C	ADDRESS, CITY, STATE, ZIP CODE ALUMET AVENUE ER, IN46321		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
IAU	the same patio d (Resident #C's n (Resident #C's n in good spirits an facility applied a (Resident #C's n physician were n situation. In speaking with about the incident because she and to attend an activ her roommate's	oors and returned with ame) at 2:49 p.m. ame), upon her return was and without injury. The a wanderguard to ame) and her family and made aware of the a (Resident #C's name) at she states she was upset her roommate had plans wity together and when family came in, she (the o go to the store without		IAU			DATE
	#C's name) not I of time unless su staff. Activity st (Resident #C's n monthly basis ar the same. The in (Resident #C's n facility unattend the risks of doing understanding. The facility is considered environment without comproning.	requested that (Resident eave the unit for a period apervised by family or taff has agreed to take ame) shopping on a and family is willing to do adividual that assisted ame) in exiting the ed has been educated on g so and has verbalized committed to providing a at for all our residents mising their quality of serve (Resident #C's axt two weeks and					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155131	B. WIN			08/24/2011
NAME OF I	DD OLUDED OD GLIDDI IED		_!		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF	PROVIDER OR SUPPLIER			7935 C	ALUMET AVENUE	
	ER MED-INN			MUNST	FER, IN46321	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE COMPLETION DATE
IAU	•	<u> </u>	+	IAU		DATE
		ity to safely leave the unit				
	1	e has expressed a desire				
	1 ^	e but sometimes lack				
	good decision ma	aking skills.				
	The Florement I	Risk Assessment Policy				
	1 *	the Administrator on				
	1 1	.m. The Social Service				
	1	responsible for the				
	procedure. The	-				
	1 ^					
		entify those at risk for				
	1 ^	e procedure included, but				
		o, the following: "1.0				
		ons will be assessed by				
	1	uring the completion of				
	1	y." "2.0 All other				
		assessed by Social				
		ss of past "no" risk scores				
	1	cognitive or behavioral				
		new diagnosis of				
	1	d. 3.0 Social Service				
	1 -	onitor, and update care				
	1	eed for elopement				
	1 1	4.0 All residents will				
	be assessed annu	ally."				
	Interview with L	PN #1 on 8/22/11 during				
		10:10 a.m., indicated she				
		when she found out				
	1	left the facility. She was				
	1	ent to get the resident and				
		ne facility. She further				
	indicated the resi	•				
		any and did not seem to				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155131	B. WIN			08/24/2	011
		1	D. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					ALUMET AVENUE		
MUNSTE	ER MED-INN			1	ER, IN46321		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	see the danger sl	ne was in at the time. The					
		ormed the LPN that if she					
		inutes she would have					
		o one would have known					
	she was gone.	o one would have known					
	sile was golle.						
	Interview with S	Social Service #1 on					
		p.m., indicated the most					
		nt Risk Assessment for					
	1 ^	s 6/22/09. She further					
		as the staff member who					
		pleted the assessments					
	and there were n	o other assessments.					
	Interview with the	he Administrator on					
		p.m., indicated the					
		-					
	1 -	ors do not have a					
	1	rm. The resident was not					
	_	ain dining room due to the					
	_	was due to the staff					
	_	esident's behavior and her					
	indicating she w	as still going to leave. It					
	was then indicat	ed with her stating she					
	was going to lea	ve and the doors not					
		by the wanderguard					
	_	It in the best interest of					
	1 -	eep her on the unit to					
	monitor her beha	-					
		w,					
	Interview with the	he Director of Nursing					
		or on 8/22/11 at 2:30					
		he thought the resident's					
	wanderguard fro	_					
	1	January 2010. It was					
	L discontinuca III .	ranuary 2010. It was					

000056

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MU A. BUIL B. WING	DING	NSTRUCTION 00	(X3) DATE COMPL	ETED	
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN			STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVENUE MUNSTER, IN46321					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	because she was would not be in they had planned roommate was g It was further indicated Reside way from when facility with them when indicated Reside way from when facility with her was also very terindicated when the elevator and sound she would Interview with the on 8/22/11 at 3:1 not sure if or white into place for Rewanderguards when the triangle of the resident and she and interval check and interval ch	· · · · · · · · · · · · · · · · · · ·						

	IT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MU A. BUII B. WIN	LDING G	NSTRUCTION 00	(X3) DATE S COMPL 08/24/2	ETED
NAME OF PROVIDER OR SUPPLIER MUNSTER MED-INN			STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVENUE MUNSTER, IN46321				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	less frequent. The who would do the resident or the frequent was also indicated behaviors and not wanderguards are unit. It was also only took off her also trying to take her wheelchair, best interest of the resident independent independent intervention wanderguard was then stressed that independence and with her all of the Interview with the 8/23/11 at 9:45 are resident had been did not know exact took place and amonthly so they yet. She further taken out of the stressed to the stressed that the stressed that independence and with her all of the stressed that the stressed that independence and with her all of the stressed that independence and with her all of the stressed that the stressed that the stressed that the stressed that independence and the stressed that the stressed that the stressed that the stressed that independence and with her all of the stressed that independence and with her all of the stressed that the stressed that independence are stressed that independence and with her all of the stressed that independence are stressed that in	ne Activity Director on a.m., indicated the n taken to the store. She actly when the outing ctivity notes are done would not be in the chart indicated the resident was					

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155131	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		100101	B. WING	PRESENTATION OF THE CORP.	08/24/2011		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7935 CALUMET AVENUE							
MUNSTER MED-INN			MUNSTER, IN46321				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION		
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	DATE		
		,					